BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

PATIENT DEMOGRAPHICS

Please print very clearly

➢ *Patient Information*

Name (Last, First, Middle): _____ **Birth Date:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Sex:** Female Male

Address: _____ **State:** _____ **Zip:** _____

Marital Status (Circle One): Single Married Partnered Divorced Widowed Separated

Referring Physician: _____ **How did you hear about us?** _____

➢ *Primary Insurance*

Insurance Company: _____ **Ins. ID #:** _____ **Group #:** _____

*Please enter the **policyholder's** information below. If the patient, is the policyholder check this box and skip to the next section* ☐

Policyholder's Name (Last, First, Middle): _____ **Birth Date:** _____

Relationship to Patient: _____ **Phone Number:** _____

➢ *Secondary Insurance*

Insurance Company: _____ **Ins. ID #:** _____ **Group #:** _____

*Please enter the **policyholder's** information below. If the patient, is the policyholder check this box and skip to the next section* ☐

Policyholder's Name (Last, First, Middle): _____ **Birth Date:** _____

Relationship to Patient: _____ **Phone Number:** _____

➢ *Assignment and Release*

I hereby authorize payment, directly to Breast Rehabilitation and Healing Center, of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the providers, staff, and billing agents of this practice to release any information required, to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agree, in full, to the above statements.

_____ _____

Signature of Patient or Guardian ***Date***

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

BILLING AND COLLECTION POLICIES

Upon scheduling and registration: *We require you to provide your medical insurance card(s), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner, or parent, we require you to provide that person's information as well. Intentionally failing to notify us of changes to your insurance coverage may constitute as fraud. By signing below, you accept and agree to these policies.*

Keeping Appointments: *To cancel an appointment, patients must call 24 hours, or more, in advance of their appointment. Failure to attend an appointment, or cancellations that occur without proper notification, allows Breast Rehabilitation and Healing Center to charge a fee of $25.00. By signing below, you accept and agree to these policies.*

Participating Insurance Plans: *We are an out-of-network provider and only in-network with Medicare and some no-fault/accident/worker's compensation carriers. It is your responsibility to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities. You are wholly responsible for your coverage limitations, regardless of whether or not you are aware of your benefit details. If you have both commercial and no-fault/worker's compensation coverage, you are responsible for providing the correct insurance at your visit. If your plan requires an authorization, and you do not provide such referral, authorization, or certification, you will be responsible for all charges that are not paid by your insurance company. By signing below, you accept and agree to these policies, and exempt yourself from any protections your insurance plan may offer you regarding this provision.*

Out-of-Network Insurance Plans: *If you have an insurance plan that we do not participate with but has out-of-network benefits, we may agree to file claims for services rendered and wait for the insurance company adjudication before billing you for the balance of the charges. If your plan notifies us that you do not have coverage for the services rendered out-of-network, you are responsible for a self-pay fee of $75, due at every visit attended. If your plan issues payment for services rendered out-of-network, you still may be responsible for some or all of the remaining balance, which we will invoice you for. Balance bills are due immediately upon receipt. If your plan makes payment directly to you, or the policyholder for services rendered, you are responsible to turn the entire payment over to us immediately upon receipt, by endorsing the check over to Breast Rehabilitation and Healing Center, along with complete copies of the explanation of benefits (you may still be responsible for payment of some or all of the balance). By signing below, you accept and agree to these policies.*

Self-Pay Patients: *If you do not have health insurance, or no out-of-network benefits, you will be responsible for payment of services at the time of arrival for your scheduled appointment. Discounts for eligible patients may be granted; however, there is no guarantee of such discounts, and may be revoked, if balances are not paid for prior to your scheduled appointment. By signing below, you accept and agree to these policies.*

Compression Bandages, Garments, and Lymphatic Pumps: *Compression bandages are not covered by insurance and are an out-of-pocket expense. Compression garments and lymphatic pump coverage is dependent on each patient's insurance plan. Out-of-pocket payments must be collected before receiving products. By signing below, you accept and agree to these policies.*

_____

Patient Name (please print clearly)

_____ _____

Signature of Patient or Guardian ***Date***

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

NOTICE OF MEDICARE THERAPY CAP

Dismiss this page only if you do not have Highmark Medicare or a Medicare Advantage plan

Each year, Medicare establishes a per-beneficiary cap on occupational, physical, and speech therapy. This means that in any given year, each Medicare beneficiary is covered for therapy services only up to a certain dollar amount, as allowed by Medicare. **In 2023, the occupational therapy cap is $2,230.00.**

The therapy cap applies to the patient, not the provider. That means that you, as a Medicare beneficiary, are covered for this amount of services in total, spread over all your providers, per calendar year.

As a courtesy, we will attempt to determine how much of your cap you have used as of the date you begin services with us. However, if you are already receiving services elsewhere, the information we obtain from Medicare may not be up to date.

Depending on your treatment needs, the entire annual cap should allow for approximately 15-20 treatment visits at our practice. This number is only an estimate and varies from patient to patient.

In some cases, for patients whose condition qualifies under Medicare's strict definition of severity, and for certain diagnoses, we may be able to obtain payment for services beyond the therapy cap as an exception. To do this, we may need to speak with your prescribing physician, and we will need to use special codes when billing Medicare. However, at any point, Medicare has the right examine your medical file, and can decide to terminate payment for services. In addition, this exception process must be authorized by congress each year, and while it is in place for 2023, there is no guarantee that it will continue.

The Medicare therapy cap applies to all direct Medicare beneficiaries. Some Medicare Advantage plans apply the caps, and some do not.

Any services rendered to Medicare beneficiaries which are not paid as a result of the therapy cap then become the responsibility of the patient.

By signing below, you agree that you have read the above, that you have been notified of Medicare's right to discontinue your treatment after the therapy cap is reached, and that you will pay Breast Rehabilitation and Healing Center for any services rendered beyond the therapy cap's coverage.

_____

Patient Name (please print clearly)

_____ _____

Signature of Patient or Guardian ***Date***

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

HIPAA Privacy Rule: *The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individually identifiable health information. The Rule requires appropriate safeguards to protect the privacy of protected health information and sets limits and conditions on the uses and disclosures that may be made of such information without an individual's authorization. Breast Rehabilitation and Healing Center is allowed to release any information requested by your paying insurance plan. By signing below, you accept and agree to these policies.*
(As defined in the Health Insurance Portability and Accountability Act ["HIPAA"] of 1996 and its regulations, as may be amended from time to time)

Physicians and Other Health Care Providers: *The privacy rule does not apply to your referring physician. By signing below, you agree that Breast Rehabilitation and Healing Center can release any relevant information to your referring physician. If you would like any other physicians or health care providers to have access to your records, please list each physician/health care provider, and their specialty below:*

Physician's Name:	**Specialty:**
_____	_____
_____	_____
_____	_____

Non-Treating and Non-Medical Persons: *The Privacy Rule prevents Breast Rehabilitation and Healing Center from disclosing any and all personal information to any person, without your consent. If you have a spouse, family member, friend, or other persons that you wish to have access to your records, please list them below:*

Name:	**Relationship to you:**
_____	_____
_____	_____
_____	_____

By signing below, you acknowledge and understand that you can change any of the foregoing agreements, at any time, by giving written notice to Breast Rehabilitation and Healing Center.

_____

Patient Name (please print clearly)

_____ _____

Signature of Patient or Guardian ***Date***

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

PATIENT MEDICAL QUESTIONNAIRE

Patient's Name: _____ **Today's Date:** _____

Please advise us of your medical history by circling yes or no for each of the following conditions:

Heart problems----------YES----------NO----------If yes, details: _____

Pacemaker----------YES----------NO----------If yes, details: _____

High Blood Pressure----------YES----------NO----------If yes, details: _____

Cancer----------YES----------NO----------If yes, details: _____

Stroke----------YES----------NO----------If yes, details: _____

Asthma----------YES----------NO----------If yes, details: _____

Pregnancy----------YES----------NO----------If yes, details: _____

Diabetes----------YES----------NO----------If yes, details: _____

Lung Disease----------YES----------NO----------If yes, details: _____

Thyroid Disease----------YES----------NO----------If yes, details: _____

Osteoporosis----------YES----------NO----------If yes, details: _____

Kidney Dysfunction----------YES----------NO----------If yes, details: _____

Inflammatory Disease----------YES----------NO----------If yes, details: _____
(Crohn's, Colitis, etc.)

Infectious Disease----------YES----------NO----------If yes, details: _____
(Hepatitis, HIV, TB, etc.)

Circulation/Vascular Dysfunction----------YES----------NO----------If yes, details: _____

Seizures/Epilepsy----------YES----------NO----------If yes, details: _____

Multiple Sclerosis----------YES----------NO----------If yes, details: _____

Parkinson's----------YES----------NO----------If yes, details: _____

Repeated Infections----------YES----------NO----------If yes, details: _____

Skin Diseases----------YES----------NO----------If yes, details: _____

Developmental Disorders----------YES----------NO----------If yes, details: _____

Recent Abdominal Surgery----------YES----------NO----------If yes, details: _____
(within 1 year)

Allergies----------YES----------NO----------If yes, details: _____

Other: _____ **Details:** _____

Height: _____ **Weight:** _____

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

PATIENT CONTRAINDICATIONS

Contraindications are defined as "conditions or circumstances that suggest or indicates that a particular technique, treatment, or drug, should not be used."

Patient's Name: _____ **Today's Date: _____**

Please indicate if you have any of the following, by circling yes or no:

General Contraindications

Malignancies----------YES----------NO

Infections of any kind----------YES----------NO

Heart Edema----------YES----------NO

Acute Bronchitis----------YES----------NO

Latex Allergies----------YES----------NO

Contraindications to Neck Treatment

Cardiac Arrhythmias----------YES----------NO

Patients over 60 years of age----------YES----------NO

Hyperthyroidism----------YES----------NO

Hypersensitivity of carotid----------YES----------NO

Contraindications of Abdominal MLD

Pregnant----------YES----------NO

Recent Abdominal Surgery----------YES----------NO

Deep Vein Thrombosis (DVT)----------YES----------NO

Crohn's Disease----------YES----------NO

Diverticulitis----------YES----------NO

Aortic Aneurysm----------YES----------NO

Unexplained Pain----------YES----------NO

Radiation over Abdomen----------YES----------NO

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

MEDICINE QUESTIONNAIRE

Patient's Name: _____ **Today's Date:** _____

Please advise us of all medications you are currently taking. This includes, but not limited to: all prescriptions, over-the-counter medication, herbals, vitamins, minerals and dietary supplements. If you have a list with you, please write "see attached" and attach a copy of your list.

Name of Medication:	**Dosage:**	**Frequency:**	**Route of Administration:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your alcohol usage? *Never ---------- Socially ---------- Weekly ---------- Daily ---------- If yes, see below*:*

***More than three (3) drinks in a day?** *Yes ---------- No* ***More than seven (7) drinks in a week?** Yes ---------- *No*

Do you use any type of tobacco products? *Yes ---------- No ---------- If yes, details:* _____

_____ _____
Signature of Patient or Guardian ***Date***

This section is for the provider only

_____ _____
Reviewed By ***Date***

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

PHOTO RELEASE PERMISSION

Photo Monitoring: *In addition to daily treatment notes and routine progress notes, we may monitor your progress by taking pictures of the affected site that is being treated (i.e., redness, swelling, rash, etc.). Your face will not be photographed, and pictures are kept private within our office (and your referring provider in some cases). Photographs are only used for treatment and research purposes. This allows us to provide the best care that we can. By signing below, you accept and agree to these policies.*

I, _____, give Breast Rehabilitation and Healing Center permission to take
(Print Full Name Here)

photographs of the affected area that is being treated. Please sign below.

_____ _____

Signature of Patient or Guardian ***Date***

BRHC Breast Rehabilitation & Healing Center
Optimal Recovery and Lymphedema Management

99 Kinderkamack Road, Suite 211, Westwood NJ, 07675
Phone: 201-497-6175 **Fax:** 201-497-6321

APPOINTMENT NO-SHOWS AND CANCELLATIONS

Cancellations: *If you need to cancel an appointment, it must be cancelled with at least 24 hours' notice, or more. A cancellation will be considered late if we receive notice with less than 24 hours. If an appointment is cancelled late, you will be charged a $25 cancellation fee. By signing below, you agree and accept this policy.*

No-Shows: *If you do not show up to your scheduled appointment or arrive more than 15 minutes late and we are unable to take you, with no notice, the missed appointment will be marked as a no-show. If you miss an appointment, you will be charged a $25 no-show fee. By signing below, you agree and accept this policy.*

According to Chapter I, section 30.3.13 of the Medicare Claims Processing Manual, which is attached to CR5613, CMS policy allows physicians, providers, and suppliers, to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries, but also charge non-Medicare patients for missed appointments and the charges for Medicare and non-Medicare are the same. The charge for a missed appointment is not a charge for service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

HOW TO CANCEL YOUR APPOINTMENT:

If you need to cancel your appointment, please call Breast Rehabilitation and Healing Center during normal office hours. If the reason for cancellation is an emergency after hours, please call and leave a voicemail notifying the front desk, and it will be received the next business day.

Breast Rehabilitation and Healing Center, requires you to provide a credit card to be kept on file. Please fill out the below section. If you do not call to cancel your appointment 24 hours or more prior, we will charge $25 to this card within 48 hours of your missed appointment.

Credit Card Number: _____

Exp. Date: _____ **Zip Code: _____**

Name on Card: _____

☐ ***Check this box if you prefer us to keep your credit on file electronically.***

_____

Patient Name (please print clearly)

_____ _____

Signature of Patient or Guardian ***Date***